

**WORKERS' COMPENSATION
COMPLAINT AGAINST THE
INDUSTRIAL SPECIAL INDEMNITY FUND (ISIF)**

CLAIMANT'S NAME AND ADDRESS	CLAIMANT'S ATTORNEY'S NAME AND ADDRESS
EMPLOYER'S NAME AND ADDRESS	EMPLOYER'S ATTORNEY'S NAME AND ADDRESS
I.C. NUMBER OF CURRENT CLAIM	WORKERS' COMPENSATION INSURANCE CARRIER'S (NOT ADJUSTERS) NAME AND ADDRESS
DATE OF INJURY	

NATURE AND CAUSE OF PHYSICAL IMPAIRMENT PRE-EXISTING CURRENT INJURY OR OCCUPATIONAL DISEASE:

STATE WHY YOU BELIEVE THAT THE CLAIMANT IS TOTALLY AND PERMANENTLY DISABLED:

DATE

SIGNATURE OF PARTY OR ATTORNEY: _____

PRINT OR TYPE NAME: _____

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20____, I caused to be served a true and correct copy of the foregoing Complaint upon:

Manager, ISIF PO Box 83720
Dept. of Administration Boise, Idaho 83720-7901

via: ☐ personal service of process
 ☐ regular U.S. Mail

Claimant's Name _____

via: ☐ personal service of process
 ☐ regular U.S. Mail

Address _____

Employer's Name _____

via: ☐ personal service of process
 ☐ regular U.S. Mail

Address _____

Surety's Name _____

via: ☐ personal service of process
 ☐ regular U.S. Mail

Address _____

☐ I have not served a copy of the Complaint upon anyone.

NOTICE: Pursuant to the provisions of Idaho Code § 72-334, a notice of claim must first be filed with the Manager of ISIF not less than 60 days prior to the filing of a complaint against ISIF.

You must attach a copy of Form IC 1001 Workers' Compensation Complaint, to this document.

An Answer must be filed on Form IC 1003 within 21 days of service in order to avoid default.